Roadrunner Foot and Ankle
13660 N 94th Drive Suite A-3
Peoria, Arizona 85381
Phone 623-933-4645 Fax 623-933-4677

Date _____

Patient's Name:_____ Patient's Social Security #:_____

Patient's Address (local)_____ Birthdate_____/_____/_____ Age:_____

City, State and Zip_____ Sex: M F Marital Status: S M W D

Phone # (local)_____ Spouse Name_____

Cell Ph #_____Work #_____ Emergency Contact_____

Responsible Party_____ Emergency Contact Phone #_____

Responsible Party Phone # _____ Primary Care Physician_____

Your E-mail_____ Primary Care Physician#_____

*These are government categories. If you need help please ask.

*Preferred Language_____ *Ethnic Group_____

*Race_____

How did you hear about us? _____ Occupation_____

EMPLOYMENT INFORMATION

Patient/Parent Employer_____ Spouse's Employer_____

Employer Address_____ Employer Address_____

City, State and Zip_____ City, State and Zip_____

INSURANCE INFORMATION – We will copy your insurance card but we need you to fill out this section!

Primary Insurance_____ Secondary Insurance_____

Ins Co Phone #_____ Ins Co Phone #_____

Ins Co Address_____ Ins Co Address_____

Policy Holder Name/ Date of Birth_____ Policy Holder Name/Date of Birth_____

ID #_____ ID #_____

PHARMACY INFORMATION

Name_____ Cross Roads_____

MEDICAL HISTORY

Name_____Date_____

Height_____Weight_____Shoe Size_____

What type of foot problems bring you to our office?_____

PAST MEDICAL HISTORY

Please check if you have any of the following:

Arthritis/Osteo Arthritis		**Liver Disease**	
Asthma		**Hep C Y or N**	
Cancer (What Kind)		**Lupus**	
COPD/Emphysema		**Psoriasis**	
Diabetes DX:	**A1C**	**Raynaud's**	
Gout		**Rheumatoid Arthritis**	
Heart Attack		**Seizures**	
High Blood Pressure		**Stomach Ulcer**	
High Cholesterol		**Stroke**	
HIV		**Thyroid Disease**	
Kidney Disease			
Dialysis Y or N		**Other:**	

Regular Medications (including over the counter) Dosage or Please Attach List:

Medication Name:	**Dosage**	**How many times per day?**

Previous Surgeries (Type and Date):

ALLERGIES

Please check if you have any of the following:

	Reaction		**Reaction**
Penicillin		**Adhesive**	
Aspirin		**Latex**	
Codeine		**Shellfish**	
Sulfa		**Iodine**	
Novocain			

Other, please specify:_____

SOCIAL HISTORY

Do you smoke? Yes or NO Number of pack(s) per day?_____ Have you ever smoked? Yes or NO
Do you drink? Yes or NO How many ounces per week?_____
Do you exercise? Yes or NO

FAMILY HISTORY

Do you have family history of (please check all that apply)

	Father	Mother	Siblings	Grandparents
Diabetes				
Heart Disease				
Bleeding Disorders				
Stroke				
Gout				
Rheumatoid Arthritis				
High Blood Pressure				
Cancer Type				
Other:				

Please circle all that apply to YOU or circle NONE:

NEURO:	tingling numbness burning sciatica pins and needles Other:	NONE
PSYCHIATRIC:	depression anxiety stress bipolar dementia Other:	NONE
EYES:	visual problem blurry vision macular degeneration Other:	NONE
NOSE, THROAT & MOUTH:	nasal allergies nose bleeds swallowing difficulty frequent sore throats speech problems dental problems tongue problems canker sores	NONE
NECK:	swollen glands thyroid problems Other:	NONE
CHEST:	chest pain asthma shortness of breath cough TB Other:	NONE
HEART & VASCULAR:	murmurs palpitations valve problems angina swollen legs varicose veins cramps when walking cold legs/feet-rest pain Other:	NONE
INTESTINAL:	colitis ulcer gastritis Barrett's esophagus polyps constipation Other:	NONE
URINARY:	urinary problems urinary frequency burning kidney stones Other:	NONE
SKIN:	rashes thick nails itching skin cancer Other:	NONE
SYSTEMIC:	weight loss fever night sweats trouble sleeping loss of energy anemia bruise easily Other:	NONE
MUSCULOSKELETAL:	joint pain joint swelling joint stiffness gout R.As back pain Other:	NONE

Signature of Patient/Responsible Party AND DATE_____

DPM Reviewed, sign and date_____

RELEASE OF INFORMATION/INSURANCE ASSIGNMENT
DO WE HAVE PERMISSION TO:

Leave a message on you answering machine at home? _____YES _____NO
Leave a message at your place of employment? _____YES _____NO
Discuss your medical condition with any member of your household? _____YES _____NO
If YES, with whom?_____

I authorize the release of any medical information necessary to process claims for services I have been provided. I permit a copy of this authorization to be used in place of the original. I authorize Roadrunner Foot and Ankle to apply for benefits on my behalf for any covered services. I request that payment from the insurance company be made directly to Roadrunner Foot and Ankle. I authorize Roadrunner Foot and Ankle to contact and forward any pertinent medical information to my other physician for their records. I further understand that I am responsible for all charges whether or not they are paid by my insurance company. I certify that the above information is correct.

Signature of Patient/Responsible Party:_____Date:_____

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received Roadrunner Foot and Ankle Notice of Privacy Practices. (Copies are available at the front desk.)

_____ _____
Signature of Patient/Responsible Party Date

FOR OFFICE USE ONLY
Documentation of Good Faith Efforts
To obtain patient's acknowledgement that they received provider's
Notice of Privacy Practices
(For use when acknowledgement cannot be obtained from patient)

The patient presented to the office and was provided with a copy of Covered Entity's notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- _____ Patient refused to sign
- _____ Patient was unable to sign or initial because:_____
- _____ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- _____ Other reason (describe): _____

_____ _____
Signature of Employee Completing Form Date

Roadrunner Foot and Ankle
13660 N 94th Dr. Suite A-3 Peoria, AZ 85381
Ph: 623-933-4645 Fax: 6239334677

NO SHOWS AND LATE CANCELLATIONS POLICY

In an effort to serve our patients and the community well, we must utilize our time efficiently. When a patient makes an appointment, time is set aside for their needs, and work is performed to prepare their record for the visit. When a scheduled visit is not completed, there is a loss for another patient who could have used that available time, as well as wasted staff time. Therefore, we ask that when a scheduled visit cannot be met, it be cancelled at least twenty-four hours prior to the time of the appointment. For late cancellations or not showing for a scheduled appointment, a $50 fee will be charged.

I acknowledge receipt of this policy and agree to make payment for the amount of $50 in the event that I cancel an appointment without appropriate notice or neglect to show up for a scheduled appointment.

Signature of Patient/Responsible Party:_____ Date:_____

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We strive to provide the most up to date and cost effective treatment, therapy and products for your foot and ankle care. Please understand that payment of your bill is considered a part of your treatment.

Medicare patients are required to meet a $140.00 calendar year deductible. If you have a supplemental or secondary insurance please inform our staff prior to your visit.

Non-covered medical supplies or services must be paid in full at the time of the visit.

Indemnity insurance plans such as Blue Cross/Blue Shield will be billed. You will be responsible for any co-insurance and deductible amounts. If we do not receive payment within 90 days, we will transfer the balance to your responsibility for payment.

Patients that do not have medical insurance will be required to pay for the services rendered in full on the date of service. We will try to accommodate patients by supplying an estimate prior to seeing the doctor. Payment plans are not accepted.

We require payment in the form of cash, money order, check or Visa/Master Card/Discover.

Copays and Balances are due at the time of service.

There will be a $5.00 billing fee for copays not paid on the date of service.

For balances not paid in full within 30 days of the initial statement, there will be a $5.00 rebilling fee for each additional monthly statement that is sent out.

There will be a $25.00 fee for returned checks.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Signature of Witness Date